DELAWARE HEALTH AND SOCIAL SERVICES
Division of Developmental Disabilities Services

Physical Examination

Name: _____ MCI #: _____ Sex: _____ D.O.B.: _____

Exam Date: _____ Ht: _____ Wt: _____ Temp: _____ BP: _____

P: _____ R: _____ Pulse Ox: _____

Allergies: _____

_____

Physical Examination:	Normal	Abnormal	Comments
Scalp/Hair			
Ears/Hearing			
Eyes/Vision			
Nose/Mouth/Pharynx			
Gum Check/Oral Health			
Neck/Thyroid			
Skin/Nails			
Chest/Breast			
Heart			
Lungs			
Spine			
Abdomen			
Genitalia (external)			
Prostate			
Pelvic/Pap Smear			
Upper Extremities			
Lower Extremities			

Colon/rectal Cancer Screening:_____ **Guaiac Result**:_____

Last PPD: _____ Results: _____ If Positive Hx - Active S/S: Yes _____ No_____

Immunizations

Immunization	Date Last Given	Current Y/N	Current Medical Diagnosis	
Td or Tdap			1.	
Influenza			2.	
Pneumococcal (PPSV23)			3.	
Zoster			4.	
Hepatitis B vaccine			5.	
Varicella (Chicken Pox)			6.	
Measles, Mumps, Rubella			7.	
Human Papillomavirus			8.	
Other:			9.	

Immunizations given at time of exam:_____

_____

Diet: _____

Form: NS FRM 206 Approved: 3/26/18
Amended: 5/24/2018

Risk factors for Obesity identified?_____

Mental and Behavioral Health: Are signs of Depression, Dementia, Abuse or Neglect present? Is counseling recommended?_____

Other: _____

_____

Lab Tests, Screenings and/or Diagnostics Ordered(PSA, Mammagram, PAP Smear, Lipids, HgA1c, LFT, Hepatitis and other Infectious disease Screening, Cardiovascular screening, Dexa Scan, STD screening, Thyroid function, Echocardiogram, etc.)

Are any recommended screening refused by individual/Guardian/surrogate Decision maker? Please document all refused screenings here: _____

_____

_____

Restrictions:	Unlimited	Limited	Avoid
Walking			
Standing			
Stooping			
Kneeling			
Lifting			
Pushing			
Pulling			
Other			

Next recommended physical exam - Annual _____ 2 yrs _____ 3 yrs _____

Recommendations/Referrals/Screenings: _____

_____

Adaptive Equipment:_____

_____

Medications: [Include dosage and frequency]

Was the individual informed of his/her physical status? Yes _____ No _____

If "no" or "unable", was the individual's physical status discussed with his/her surrogate/guardian?

Yes _____ No _____

Does the individual have the capacity to understand the significant benefits, risks and alternatives to proposed health care and make and communicate decisions? Yes _____ No _____

Return To: _____ Signature: _____

Address: _____ Address: _____

_____ _____

Telephone: _____